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| | 15G190 | A. BUILDING 00<br>B. WING | 03/30/2012 |

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| W0000 | | W0000 | | |

This visit was for the investigation of Complaint #IN00104522.

COMPLAINT #IN00104522: SUBSTANTIATED, Federal and state deficiencies related to the allegation are cited at W102, W104, W111, W122, W149, W153, W192, W318, W331, W340, W368, and 9999.

Dates of survey: March 22, 26, 27, 28, 29 and 30, 2012

Facility number: 000722
Provider number: 15G190
AIM number: 100234570

Surveyor: Christine Colon, Medical Surveyor III/QMRP- Team Leader

The following deficiencies also reflect state findings in accordance with 460 IAC 9.

Quality Review completed on 4/9/12 by Tim Shebel, Medical Surveyor III.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| W0102 | 483.410<br>GOVERNING BODY AND MANAGEMENT<br>The facility must ensure that specific governing body and management requirements are met.<br><br>Based on record review and interview for 1 of 1 discharged clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure the facility implemented their policy and procedures to prevent neglect of client A and to ensure the health needs of client A were met.<br><br>Findings include:<br><br>1. Please refer to W104. The governing body failed, for 1 of 1 discharged clients (client A), to implement the facility's policy and procedure to prevent neglect by failing to ensure the facility met the needs of the client, and ensured a client's health needs were not neglected.<br><br>2. Please refer to W111. The governing body failed, for 1 of 1 discharged client (client A), to ensure all pertinent information in regard to the client's health were part of the client's chart/records. | W0102 | See W 104 page 3, W 111 page 14, W 122 page 16 | 04/29/2012 |

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| | 3. Please refer to W122. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Client Protections. The facility neglected to implement their neglect policy and neglected to provide timely health care, for 1 of 1 discharged client (client A).<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-1(a) | | | |

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| W0104 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>Based on record review and interview for 1 of 1 discharged client (client A), the governing body failed to exercise operating direction over the facility to ensure implementation of its policy and procedure to prevent neglect and to provide for the client's health needs.<br><br>Findings include:<br><br>A request for the facility's internal incident and accident reports and investigation records was made on 3/22/12 at 2:00 P.M.. No internal incident/accident reports and investigation records were submitted by the facility for review.<br><br>A review of client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record indicated:<br><br>Nursing notation dated 1/9/12: "Received a call from grouphome (sic) staff Saturday stating that [client A] was coming down the steps and sat down and passed out. | W0104 | The IDT team will meet to review current risk plans and discuss any additional needs that may require risk plans. If additional risk plans are needed, they will be implemented and staff will be trained on the plans. To ensure future compliance, risk plans will be discussed and new plans, if necessary will be developed during clients annual meetings. Community Services nurse will train staff on when to call 911 and when to call a nurse/and will train all staff before they work with new clients. To ensure future compliance, Community Services Nurse and or Service Coordinator will access each situation as needed to determine and further instruct staff to contact 911 and follow proper procedures. Community Services Nurse will be trained on assessing clients within 24 hours of a change in condition. To ensure future compliance, Community Services Nurses will be monitored by the Director of Health and Safety Services weekly for three months and monthly thereafter. Community Services Nurses will be trained to utilize MITC for significant changes in care, preventing staff from beginning their shift without being informed of change. To ensure future | 04/29/2012 |

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| | Came to about 45 seconds later was aware of person, place and time. Diagnosed 3/11 with syncope. Informed staff that this appeared to be a syncope episode and just to continue to monitor and walk with [client A] when possible." The record failed to indicate a "Health Risk Plan" for the client's diagnosis of syncope. Further review failed to indicate a nursing assessment or a visit to the physician.<br><br>Nursing notation dated 2/6/12: "Received a call from staff on Sunday, 2/5/12 stating that [client A] was very weak and couldn't stand at all. She also lost control of her bowels and bladder at the table and didn't even realize it. I (Nurse) instructed staff to have her transported to the ER (Emergency Room) for evaluations and tx (treatment). Admitted to hospital with UTI (Urinary Tract Infection) and blood clot in left leg."<br><br>Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligrams) qd (everyday)."<br><br>Further review of the record indicated client A was moved to a different group home the day of her discharge from the hospital on 2/11/12 due to her not being able to go up and down stairs. No | | compliance, Director of Health and Safety Services will continue to meet with Nurses daily and access new protocol for effectiveness. | |

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| | documentation was available for review to indicate the facility's governing body assured all group home staff were trained on client A's medical needs.<br><br>Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her lab drawn."<br><br>An interview with Direct Support Professional (DSP) B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated client A's Coumadin was not held on 2/22/12 due to the group home staff not receiving the memo from the nursing staff via e-mail until 2/27/12. DSP B further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12.<br><br>Nursing notation dated 2/23/12: "Received a call from health tech stating that [client A] had an episode at workshop where she was breathing hard for a few seconds. Vitals were taken and were WNL (within normal limits). She stated she seemed normal now and that it | | | |

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| | only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns.<br><br>Nursing notation dated 2/23/12: "Received a call from North (workshop) stating that there was a small bruise on [client A]'s head that they don't believe was there this morning." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted bruise.<br><br>A request for the facility's internal incident/accident reports and investigation records was made on 3/26/12 10:30 A.M.. No reports or thorough investigation records were submitted by the facility for review.<br><br>An interview with DSP C was conducted on 3/29/12 at 5:50 P.M.. DSP C indicated when she picked client A up from workshop on 2/23/12, client A was not acting herself, was not able to talk and seemed weak. DSP C stated she walked client A back into the day program to her assigned staff and asked what was wrong | | | |

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| | with her. The day program staff told DSP client A was not acting herself all day and client A would not eat her lunch which DSP C indicated was not normal for client A. DSP C then walked client A to the Health and Safety Tech to show her how client was acting and to show her a bruise she noticed on client A's head. DSP C indicated the Health and Safety Tech called the group home nurse and informed her of the injury and how client A was acting. DSP C indicated no directives were given by the group home nurse. DSP C then transported client A to the group home and dropped her off to her assigned staff. When asked if she documented this information on an incident report DSP C stated "No, because there was no significant injury." When asked if 911 was called she stated "No."<br><br>Nursing notation dated 2/23/12: "Received call from group home staff stating that client was not acting herself. Client was able to answer questions when asked from staff. Instructed staff to take her v/s (vitals) and call me back...Staff returned call v/s wnl (within normal limits), but client was not answering any questions and staff stated that client eyes were rapidly moving from side to side. I instructed staff to call 911. Client was transported to [Hospital name] for | | | |

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| | evaluation and treatment."<br><br>An interview with DSP A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated when client A was dropped off at the group home at 4:15 P.M., she was not acting herself. DSP A indicated client A could not talk and was slouched in her wheelchair. DSP A indicated three attempts were made to contact the group home nurse and Service Coordinator, but neither could be reached. DSP A indicated DSP B then called the emergency nursing phone. When the on call nurse called back around 6:00 P.M., they informed her client A's condition of not being able to talk and her slouching in her wheelchair. The on call nurse directed the staff to take client A's vitals and call her back. Client A's vitals were taken and they read 163/99 with a pulse of 47 and a temperature of 90.5. The group home staff then called the on call nurse back and as they were giving her client A's vitals, client A's eyes began rolling in the back of her head. DSP A indicated that is when the on call nurse gave directives to call 911. DSP A indicated the paramedics arrived around 6:15 P.M..<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12...He stated (verbal order) to hold it until after | | | |

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| | she has her lab drawn on Monday 2/27/12."<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being informed to hold it before administering and further indicated the group home did not receive the memo from the nursing staff via e-mail until 2/27/12. DSP A further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12.<br><br>Further review of client A's record indicated: "Health Risk Plan dated 11/3/11-Client has diagnosis of hypertension...Health Risk Plan dated 11/3/11-Client has diagnosis of hyperthyroidism...Health Risk Plan dated 11/3/11-Client has diagnosis of constipation and or bowel obstruction related to hyperthyroidism...Health Risk plan dated 11/3/11-Client is at risk for falls. Gait is unsteady...Health Risk Plan dated 11/3/11-At risk for impaired circulation related to fractured clavicle."<br><br>A request for documentation to show all staff working at the group home and day | | | |

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| | services were trained on client A's "Health Risk Plans" and health care needs was made on 3/28/12 at 2:30 P.M.. The group home Licensed Practical Nurse (LPN) did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" and health care needs was made on 3/29/12 at 3:00 P.M.. The group home LPN did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" was made on 3/30/12. The Service Coordinator and group home LPN indicated there was no documentation to indicate all group home staff were trained on client A's "Health Risk Plans" and health care needs.<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated she never received any training on any of client A's "Health Risk Plans" or medical concerns.<br><br>An interview with DSP B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated she never received any training | | | |

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| | on any of client A's "Health Risk Plans" or medical concerns.<br><br>An interview with the day program Health and Safety Tech (HST) was conducted on 3/30/12 at 11:00 A.M.. The (HST) indicated she contacted the nurse on 2/23/12 to make her aware of client A's rapid breathing and was directed to keep an eye on her. The HST also indicated she contacted the nurse later in the day to make her aware of an injury of unknown origin and again was told to monitor her. When asked if there were any incident reports documented on the incidents the HST stated "No." When asked if 911 was called when staff noticed the change in client A's breathing, the HST stated "No."<br><br>A review of "Death Investigation-Adequete (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with Service Coordinator A dated 2/24/12: "I got a phone call from [group home name] staff on 2/23/12 stating that they were trying to reach the nurse but could not get a hold of her, that was about consumer bleeding but not badly, location of bleeding was indicated. I [Service Coordinator A name] told that [group home nurse name] was at the | | | |

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| | office, they said they could not reach her. I said I will have her call you. Then I called [group home nurse name] at the office I told her about the request from group home staff and she needs to call there. I did not hear anything else until 6:30 P.M. on 2/23/12 when I got a call from Area Manager. She said the group home was trying to reach me because consumer was going to the hospital...Consumer was prescribed a wheelchair and was moved temporarily to [group home name]."<br><br>Interview with day program DSP D dated 2/24/12: "I worked with [client A] on 2/23/12. I was not on duty when she went to the hospital. Prior to leaving day service [client A] seemed to be very weak when being toileted. Seeming to be spaced out...When [client A] came back to day service from hospital she was in a wheelcahir and seemed to be weak. No special training to render services. I did have health and safety tech look at [client A] she looked different to me. When staff brought her in to me at 9:50 A.M. they told me of a med error. I asked I needed to know anything else and that her arm was bleeding it was cleaned up and nurse knew about it."<br><br>Interview with day program DSP E dated 2/24/12: "I worked with [client A] | | | |

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| | Wednesday 2/22/12...I worked at the day program yesterday. I noticed while working with her that her breathing has always been shakey to me and she was thirsty all the time...No I was not trained to render care for [client A]."<br><br>Interview withday program DSP F datetd 2/24/12: "No training for her (client A) in particular."<br><br>Interview with day program Health and Safety Tech dated 2/24/12: "I got a call on 2/23/12 by the residential nurse that the staff at the group home had made an error for meds for [client A], and were to be sure to make me aware when they brought her into the center...I knew in the last year and a half that [client A] was falling down alot and she wasn't herself anymore, a little more weak, less talkative not smiling as much, more quiet. Earlier in the afternoon I did check blood pressure, because staff had mentioned that she was breathing funny. Did take and it was 113/77 pulse 61. Called the residential nurse about my concerns and she said that was okay for [client A]. Again I called her toward the time staff was picking [client A] up to go home, because her staff had noticed a bruise on the top of her head...I was told her medication could cause her to have unexplained bruising." | | | |

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| ARC OF NORTHWEST INDIANA INC, THE | 120 AVENUE C<br>GRIFFITH, IN 46319 |

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| | Interview with DSP A dated 2/24/12: "On February 23, 2012, [DSP A] came into work at 4 P.M. at [Group home name] where she came in contact with client A at 4:15 P.M.. [DSP A] was on duty at the time the client went to the hospital. [DSP A] states that the consumer looked pale and was slumped in her wheelchair. [DSP A] did not call for for help of anyone, another staff called. The consumer was not alert or verbal while in [DSP A]'s care. [DSP A] tried to keep consumer lifted by placing her arm under consumer's arm. [DSP A] came off vacation on Monday 2/20/12 and consumer was at the group home, she had not been trained on her...[DSP A] had to call for assistance from a different staff on a separate occasion of [client A] falling on the floor...states she tried to contact [Service Coordinator name] on several occasions to get training on consumer but her calls were not answered...Did not see a risk plan in the house, but she did see the MAR (Medical Administration Record)."<br><br>Interview with DSP B dated 2/24/12: "[DSP B] worked with client A last on 4/23/12 (sic) [DSP B] was on duty when the consumer went to the hospital. [DSP B] states the consumer was not acting her normal self. Consumer words were slured | | | |

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| | (sic) but consumer barely said anything at all which was not normal. There was no life saving measures taken but [DSP B] did check client A's vital (sic) and found that the consumer's pulse low (it read 42). [DSP B] called the emergency phone to report that the consumer temperature was 90.5 degrees. The nurse instructed [DSP B] to call 911. [DSP A and DSP B tried to hold consumer up in her wheelchair but they never took her out of chair. [DSP B] states that she was not trained on meeting the care of the consumer...[DSP B] have (sic) not seen a risk plan at the house, but there is a MAR."<br><br>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 2:55 P.M.. The LPN indicated she did not assess client A after each incident she was made aware of. When asked if client A was seen by a physician after the mentioned incidents, the LPN statd "No." When asked if the incident of client A's arm bleeding on 2/23/12 was documented, she stated "No." When asked if 911 was called immediately when the incidents of client A's change in breathing incidents occurred, the LPN stated "No."<br><br>A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/06 was completed at the | | | |

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| | facility's administrative office on 4/26/10 at 1:36 P.M., and indicated: "In order to protect the general welfare of the clients, [Facility name] has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff...prohibits all abuse, neglect and exploitation of our clients...Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure...Neglect is defied as knowingly placing a client in a situation that poses a threat to his/her health and well being...Examples include, but are not limited to depriving a client of food, clothing, shelter or medical care."<br><br>A review of the facility's "When To Call A Nurse" policy/procedure no date, noted was conducted on 3/28/12 at 2:10 P.M.. The policy/procedure indicated: "The Nurse assigned to the group home is to be contacted regarding any changes in a client's medical condition. if no answer, leave a message and wait 30 minutes for a return call. If no return call in 30 minutes; call the nurse's emergency phone...CALL 911 FIRST (BEFORE CALLING THE NURSE), IF A CLIENT IS IN A LIFE-THREATENING SITUATION SUCH AS; UNCONTROLLED BLEEDING, DIFFICULTY BREATHING, SEVERE | | | |

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| | CHEST PAIN, OR UNRESPONSIVENESS. NOTIFY THE NURSE OF THE 911 CALL AS SOON AS POSSIBLE, Anytime that you call a nurse for anything other than a question, an incident report should be filled out."<br><br>Review of client A's "Indiana State Department of Health Certificate of Death" dated 3/28/12 was conducted on 3/30/12 at 1:30 P.M.. The document indicated client A's cause of death was sudden cardiac arrest and she expired at 8:30 P.M. on 2/23/12.<br><br>No further documented information was available for review to ensure that the governing body was monitoring the implementation of its Abuse and Neglect Policy and Procedure and it's "When to Call a Nurse" policy and procedure.<br><br>The governing body failed to exercise general policy and operating direction over the facility as it neglected to implement their neglect policy and neglected to provide timely health care for 1 of 1 discharged client (client A). Please refer to W149.<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-1(a) | | | |

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| W0111 | 483.410(c)(1)<br>CLIENT RECORDS<br>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.<br><br>Based on record review and interview for 1 of 1 discharged client (client A), the facility failed to ensure all pertinent information in regard to the client's health were part of the client's chart/records.<br><br>Findings include:<br><br>A review of client A's record was conducted at the facility's administrative office on 3/22/12 at 2:55 P.M.. A review of client A's record failed to indicate any documentation on 2/23/12 in regards to her arm bleeding.<br><br>A review of "Death Investigation-Adequate (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with Service Coordinator A dated 2/24/12: "I got a phone call from [group home name] staff on 2/23/12 stating that they were trying to reach the nurse but could not get a hold of her, that | W0111 | Community Services Nurses will be re-trained by the Director of Health and Safety Services on new nursing protocols which will include documentation, when assessments are required by the nurse and or physician. | 04/29/2012 |

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| | was about consumer bleeding but not badly, location of bleeding was indicated. I [Service Coordinator A name] told that [group home nurse name] was at the office, they said they could not reach her. I said I will have her call you. Then I called [group home nurse name] at the office I told her about the request from group home staff and she needs to call there. I did not hear anything else until 6:30 P.M. on 2/23/12 when I got a call from Area Manager. She said the group home was trying to reach me because consumer was going to the hospital...Consumer was prescribed a wheelchair and was moved temporarily to [group home name]."<br><br>Interview with day program DSP D dated 2/24/12: "I worked with [client A] on 2/23/12. I was not on duty when she went to the hospital. Prior to leaving day service [client A] seemed to be very weak when being toileted. Seeming to be spaced out...When [client A] came back to day service from hospital she was in a wheelchair and seemed to be weak. No special training to render services. I did have health and safety tech look at [client A] she looked different to me. When staff brought her in to me at 9:50 A.M. they told me of a med error. I asked if I needed to know anything else and informed that her arm was bleeding it was | | | |

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| | cleaned up and nurse knew about it."<br><br>An interview with the LPN was conducted on 3/28/12 at 12:30 P.M.. The LPN indicated client A's was not assessed by the facility's nurse and she was not seen by a physician for the mentioned incident. The LPN further indicated there was no documentation in client A's record about her arm bleeding.<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-1(a) | | | |

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| W0122 | 483.420<br>CLIENT PROTECTIONS<br>The facility must ensure that specific client protections requirements are met.<br><br>Based on record review and interview, the Condition of Participation of Client Protections was not met as the facility neglected to implement their neglect policy and neglected to provide timely health care for 1 of 1 deceased client (client A).<br><br>Findings include:<br><br>Please refer to W149. The facility neglected to implement their neglect policy and neglected to provide adequate health care for client A who needed health and emergency care interventions.<br><br>Please refer to W153. The facility failed for 1 of 1 investigation record reviewed involving 1 of 1 deceased client (client A), to report immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.<br><br>Please refer to W154. The facility failed to provide written evidence thorough investigations were conducted for incidents involving 1 of 1 deceased client | W0122 | DSP's were trained on 4/5/12 on emergency interventions and appropriate reporting.<br>To ensure future compliance, all new staff will be trained before working with clients; all staff will be re-trained annually. | 04/29/2012 |

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| | (client A.)<br><br>Please refer to W157. The facility failed to take effective corrective action to prevent client A's future occurrences of injury.<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-2(a) | | | |

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| W0149 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>Based on record review and interview, the facility neglected to implement their neglect policy and neglected to provide adequate emergency health care for 1 of 1 discharged client (client A), who needed medical attention.<br><br>Findings include:<br><br>A review of client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record indicated:<br><br>Nursing notation dated 1/9/12: "Received a call from grouphome (sic) staff Saturday stating that [client A] was coming down the steps and sat down and passed out. Came to about 45 seconds later was aware of person, place and time. Diagnosed 3/11 with syncope. Informed staff that this appeared to be a syncope episode and just to continue to monitor and walk with [client A] when possible." The record failed to indicate a "Health Risk Plan" for the client's diagnosis of syncope. Further review failed to indicate a nursing | W0149 | See W 104 page 3, W 111 page 14 | 04/29/2012 |

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| | assessment or a visit to the physician.<br><br>Nursing notation dated 2/6/12: "Received a call from staff on Sunday, 2/5/12 stating that [client A] was very weak and couldn't stand at all. She also lost control of her bowels and bladder at the table and didn't even realize it. I (Nurse) instructed staff to have her transported to the ER (Emergency Room) for evaluations and tx (treatment). Admitted to hospital with UTI (Urinary Tract Infection) and blood clot in left leg."<br><br>Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligrams) qd (everyday)."<br><br>Further review of the record indicated client A was moved to a different group home the day of her discharge from the hospital on 2/11/12 due to her not being able to go up and down stairs. No documentation was available for review to indicate all staff at the group home were trained on client A's medical needs.<br><br>Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent | | | |

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| | memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her lab drawn."<br><br>An interview with Direct Support Professional (DSP) B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being aware of the order and not receiving the memo from the nursing staff via e-mail until 2/27/12. DSP B further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12.<br><br>Nursing notation dated 2/23/12: "Received a call from health tech stating that [client A] had an episode at workshop where she was breathing hard for a few seconds. Vitals were taken and were WNL (within normal limits). She stated she seemed normal now and that it only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns.<br><br>Nursing notation dated 2/23/12: | | | |

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| | "Received a call from North (workshop) stating that there was a small bruise on [client A]'s head that they don't believe was there this morning." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted bruise.<br><br>An interview with DSP C was conducted on 3/29/12 at 5:50 P.M.. DSP C indicated when she picked client A up from workshop on 2/23/12, client A was not acting herself, was not able to talk and seemed weak. DSP C stated she walked client A back into the day program to her assigned staff and asked what was wrong with her. The day program staff told DSP client A was not acting herself all day and client A would not eat her lunch which DSP C indicated was not normal for client A. DSP C then walked client A to the Health and Safety Tech to show her how client was acting and to show her a bruise she noticed on client A's head. DSP C indicated the Health and Safety Tech called the group home nurse and informed her of the injury and how client A was acting. DSP C indicated no directives were given by the group home nurse. DSP C then transported client A to the group home and dropped her off to her assigned staff. When asked if she | | | |

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| | documented this information on an incident report DSP C stated "No, because there was no significant injury." When asked if 911 was contacted she stated "No."<br><br>Nursing notation dated 2/23/12: "Received call from group home staff stating that client was not acting herself. Client was able to answer questions when asked from staff. Instructed staff to take her v/s (vitals) and call me back...Staff returned call v/s wnl (within normal limits), but client was not answering any questions and staff stated that client eyes were rapidly moving from side to side. I instructed staff to call 911. Client was transported to [Hospital name] for evaluation and treatment."<br><br>An interview with DSP A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated when client A was dropped off at the group home at 4:15 P.M., she was not acting herself. DSP A indicated client A could not talk and was slouched in her wheelchair. DSP A indicated three attempts were made to contact the group home nurse and Service Coordinator, but neither could be reached. DSP A indicated DSP B then called the emergency nursing phone. When the on call nurse called back around 6:00 P.M., they informed her client A's condition of | | | |

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| | not being able to talk and her slouching in her wheelchair. The on call nurse directed the staff to take client A's vitals and call her back. Client A's vitals were taken and they read 163/99 with a pulse of 47 and a temperature of 90.5. The group home staff then called the on call nurse back and as they were giving her client A's vitals, client A's eyes began rolling in the back of her head. DSP A indicated that is when the on call nurse gave directives to call 911. DSP A indicated the paramedics arrived around 6:15 P.M..<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12...He stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12."<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being informed to hold it before administering and further indicated the group home did not receive the memo from the nursing staff via e-mail until 2/27/12. DSP A further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on | | | |

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| | 2/11/12.<br><br>Further review of client A's record indicated: "Health Risk Plan dated 11/3/11-Client has diagnosis of hypertension...Health Risk Plan dated 11/3/11-Client has diagnosis of hyperthyroidism...Health Risk Plan dated 11/3/11-Client has diagnosis of constipation and or bowel obstruction related to hyperthyroidism...Health Risk plan dated 11/3/11-Client is at risk for falls. Gait is unsteady...Health Risk Plan dated 11/3/11-At risk for impaired circulation related to fractured clavicle."<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" and health care needs was made on 3/28/12 at 2:30 P.M.. The group home Licensed Practical Nurse (LPN) did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" and health care needs was made on 3/29/12 at 3:00 P.M.. The group home LPN did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home and day | | | |

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| | services were trained on client A's "Health Risk Plans" was made on 3/30/12. The Service Coordinator and group home LPN indicated there was no documentation to indicate all group home staff were trained on client A's "Health Risk Plans" and health care needs.<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated she never received any training on any of client A's "Health Risk Plans" or medical concerns.<br><br>An interview with DSP B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated she never received any training on any of client A's "Health Risk Plans" or medical concerns.<br><br>An interview with the day program Health and Safety Tech (HST) was conducted on 3/30/12 at 11:00 A.M.. The (HST) indicated she contacted the nurse on 2/23/12 to make her aware of client A's rapid breathing and was directed to keep an eye on her. The HST also indicated she contacted the nurse later in the day to make her aware of an injury of unknown origin and again was told to monitor her. When asked if there were any incident reports documented on the incidents the HST stated "No." When asked if 911 was | | | |

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| | called when staff noticed the change in client A's breathing, the HST stated "No."<br><br>A review of "Death Investigation-Adequete (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with Service Coordinator A dated 2/24/12: "I got a phone call from [group home name] staff on 2/23/12 stating that they were trying to reach the nurse but could not get a hold of her, that was about consumer bleeding but not badly, location of bleeding was indicated. I [Service Coordinator A name] told that [group home nurse name] was at the office, they said they could not reach her. I said I will have her call you. Then I called [group home nurse name] at the office I told her about the request from group home staff and she needs to call there. I did not hear anything else until 6:30 P.M. on 2/23/12 when I got a call from Area Manager. She said the group home was trying to reach me because consumer was going to the hospital...Consumer was prescribed a wheelchair and was moved temporarily to [group home name]."<br><br>Interview with day program DSP D dated 2/24/12: "I worked with [client A] on | | | |

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| | 2/23/12. I was not on duty when she went to the hospital. Prior to leaving day service [client A] seemed to be very weak when being toileted. Seeming to be spaced out...When [client A] came back to day service from hospital she was in a wheelcahir and seemed to be weak. No special training to render services. I did have health and safety tech look at [client A] she looked different to me. When staff brought her in to me at 9:50 A.M. they told me of a med error. I asked I needed to know anything else and that her arm was bleeding it was cleaned up and nurse knew about it."<br><br>Interview with day program DSP E dated 2/24/12: "I worked with [client A] Wednesday 2/22/12...I worked at the day program yesterday. I noticed while working with her that her breathing has always been shakey to me and she was thirsty all the time...No I was not trained to render care for [client A]."<br><br>Interview withday program DSP F datetd 2/24/12: "No training for her (client A) in particular."<br><br>Interview with day program Health and Safety Tech dated 2/24/12: "I got a call on 2/23/12 by the residential nurse that the staff at the group home had made an error for meds for [client A], and were to | | | |

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| | be sure to make me aware when they brought her into the center...I knew in the last year and a half that [client A] was falling down alot and she wasn't herself anymore, a little more weak, less talkative not smiling as much, more quiet. Earlier in the afternoon I did check blood pressure, because staff had mentioned that she was breathing funny. Did take and it was 113/77 pulse 61. Called the residential nurse about my concerns and she said that was okay for [client A]. Again I called her toward the time staff was picking [client A] upto go home, because her staff had noticed a bruise on the top of her head...I was told her medication could cause her to have unexplained bruising."<br><br>Interview with DSP A dated 2/24/12: "On February 23, 2012, [DSP A] came into work at 4 P.M. at [Group home name] where she came in contact with client A at 4:15 P.M.. [DSP A] was on duty at the time the client went to the hospital. [DSP A] states that the consumer looked pale and was slumped in her wheelchair. [DSP A] did not call for for help of anyone, another staff called. The consumer was not alert or verbal while in [DSP A]'s care. [DSP A] tried to keep consumer lifted by placing her arm under consumer's arm. [DSP A] came off vacation on Monday 2/20/12 and | | | |

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| | consumer was at the group home, she had not been trained on her...[DSP A] had to call for assistance from a different staff on a separate occasion of [client A] falling on the floor...states she tried to contact [Service Coordinator name] on several occasions to get training on consumer but her calls were not answered...Did not see a risk plan in the house, but she did see the MAR (Medical Administration Record)."<br><br>Interview with DSP B dated 2/24/12: "[DSP B] worked with client A last on 4/23/12 (sic) [DSP B] was on duty when the consumer went to the hospital. [DSP B] states the consumer was not acting her normal self. Consumer words were slured (sic) but consumer barely said anything at all which was not normal. There was no life saving measures taken but [DSP B] did check client A's vital (sic) and found that the consumer's pulse low (it read 42). [DSP B] called the emergency phone to report that the consumer temperature was 90.5. The nurse instructed [DSP B] to call 911. [DSP A and DSP B tried to hold consumer up in her wheelchair but they never took her out of chair. [DSP B] states that she was not trained on meeting the care of the consumer...[DSP B] have (sic) not seen a risk plan at the house, but there is a MAR." | | | |

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| | An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 2:55 P.M.. The LPN indicated she did not assess client A after each incident she was made aware of. When asked if client A was seen by a physician after the mentioned incidents, the LPN statd "No." When asked if the incident of client A's arm bleeding on 2/23/12 was documented, she stated "No." When asked if 911 was called immediately when the incidents of client A's change in breathing incidents occurred, the LPN stated "No."<br><br>A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/06 was completed at the facility's administrative office on 3/30/12 at 12:15 P.M., and indicated: "In order to protect the general welfare of the clients, [Facility name] has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff...prohibits all abuse, neglect and exploitation of our clients...Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure...Neglect is defined as knowingly placing a client in a situation that poses a threat to his/her health and well being...Examples include, but are not limited to, depriving a client of food, | | | |

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| | clothing, shelter or medical care."<br><br>Review of client A's "Indiana State Department of Health Certificate of Death" dated 3/28/12 was conducted on 3/30/12 at 1:30 P.M.. The document indicated client A's cause of death was sudden cardiac arrest and she expired at 8:30 P.M..<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-2(a) | | | |

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| W0153 | 483.420(d)(2)<br>STAFF TREATMENT OF CLIENTS<br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>Based on record review and interview, the facility failed for 1 of 1 investigation records reviewed involving 1 of 1 discharged clients (client A), to report immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.<br><br>Findings include:<br><br>A review of client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record indicated:<br><br>Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligrams) qd (everyday)."<br><br>Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold | W0153 | See W 104 page 3, W 111 page 14 Community Services Nurse will be trained on appropriate BDDS reporting.<br>To ensure future compliance, the Director of Health and Safety services will monitor weekly for three weeks and monthly thereafter. | 04/29/2012 |

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| | Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her lab drawn."<br><br>An interview with Direct Support Professional (DSP) B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being aware of the order and not receiving the memo from the nursing staff via e-mail until 2/27/12. No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident.<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12...He stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12." No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident.<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated | | | |

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| | client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being informed to hold it before administering and further indicated the group home did not receive the memo from the nursing staff via e-mail until 2/27/12. No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident.<br><br>A review of "Death Investigation-Adequete (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with Service Coordinator A dated 2/24/12: "I got a phone call from [group home name] staff on 2/23/12 stating that they were trying to reach the nurse but could not get a hold of her, that was about consumer bleeding but not badly, location of bleeding was indicated. I [Service Coordinator A name] told that [group home nurse name] was at the office, they said they could not reach her. I said I will have her call you. Then I called [group home nurse name] at the office I told her about the request from group home staff and she needs to call there. I did not hear anything else until 6:30 P.M. on 2/23/12 when I got a call | | | |

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| | from Area Manager. She said the group home was trying to reach me because consumer was going to the hospital...Consumer was prescribed a wheelchair and was moved temporarily to [group home name]." No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident.<br><br>Interview with day program DSP D dated 2/24/12: "I worked with [client A] on 2/23/12...When staff brought her in to me at 9:50 A.M. they told me of a med error. I asked I needed to know anything else and that her arm was bleeding it was cleaned up and nurse knew about it." No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident.<br><br>Interview with day program Health and Safety Tech dated 2/24/12: "I got a call on 2/23/12 by the residential nurse that the staff at the group home had made an error for meds for [client A], and were to be sure to make me aware when they brought her into the center." No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident. | | | |

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| | An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 2:55 P.M.. The LPN indicated she did not assess client A after each incident she was made aware of. When asked if client A was seen by a physician after the mentioned incidents, the LPN stated "No." When asked if the incident of client A's arm bleeding on 2/23/12 was documented and reported to the administrator and BDDS, she stated "No." When asked if the medication error was immediately reported to the administrator and BDDS, the LPN stated "No."<br><br>An interview was conducted with the Service Coordinator (SC) at the facility's administrative office on 3/28/12 at 2:20 P.M.. The SC indicated incidents are to be reported immediately to the administrator and within 24 hours to BDDS. When asked if the documented incidents was immediately reported, the SC stated "No."<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-2(a) | | | |

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| W0318 | 483.460<br>HEALTH CARE SERVICES<br>The facility must ensure that specific health care services requirements are met. | W0318 | See W 104 page 3, W 111 page 14 | 04/29/2012 |

Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate nursing and emergency services for 1 of 1 deceased client (client A).

Findings include:

Please refer to W331. The facility failed for 1 of 1 discharged client (client A) by not ensuring client A received nursing and emergency services according to her medical needs.

Please refer to W339. The facility failed for 1 of 1 discharged client (client A), to develop a plan for her diagnosis of syncope

Please refer to W340. The facility nursing services failed to assure staff were trained in health care needs for 1 of 1 discharged client (client A).

Please refer to W368. The facility failed to assure 1 of 1 discharged client (client

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| | A), received medications in compliance with the physician's orders.<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-6(a) | | | |

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| W0331 | 483.460(c)<br>NURSING SERVICES<br>The facility must provide clients with nursing services in accordance with their needs.<br><br>Based on record review and interview, the facility failed for 1 of 1 discharged client (client A) to ensure she received nursing services and emergency care according to her medical needs.<br><br>Findings include:<br><br>A review of client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record indicated:<br><br>Nursing notation dated 1/9/12: "Received a call from grouphome (sic) staff Saturday stating that [client A] was coming down the steps and sat down and passed out. Came to about 45 seconds later was aware of person, place and time. Diagnosed 3/11 with syncope. Informed staff that this appeared to be a syncope episode and just to continue to monitor and walk with [client A] when possible." Further review failed to indicate a nursing assessment or a visit to the physician.<br><br>Nursing notation dated 2/6/12: "Received a call from staff on Sunday, 2/5/12 stating | W0331 | See W 104 page 3, W 111 page 14 | 04/29/2012 |

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| | that [client A] was very weak and couldn't stand at all. She also lost control of her bowels and bladder at the table and didn't even realize it. I (Nurse) instructed staff to have her transported to the ER (Emergency Room) for evaluations and tx (treatment). Admitted to hospital with UTI (Urinary Tract Infection) and blood clot in left leg."<br><br>Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligrams) qd (everyday)."<br><br>Further review of the record indicated client A was moved to a different group home the day of her discharge from the hospital on 2/11/12 due to her not being able to go up and down stairs. No documentation was available for review to indicate all staff at the group home were trained on client A's medical needs.<br><br>Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her lab drawn." | | | |

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| | An interview with Direct Support Professional (DSP) B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated client A's Coumadin was not held on 2/22/12 due to the group home staff not receiving the memo from the nursing staff via e-mail until 2/27/12. DSP B further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12.<br><br>Nursing notation dated 2/23/12: "Received a call from health tech stating that [client A] had an episode at workshop where she was breathing hard for a few seconds. Vitals were taken and were WNL (within normal limits). She stated she seemed normal now and that it only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns.<br><br>Nursing notation dated 2/23/12: "Received a call from North (workshop) stating that there was a small bruise on [client A]'s head that they don't believe was there this morning." No further documentation was available for review | | | |

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| | in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted bruise.<br><br>An interview with DSP C was conducted on 3/29/12 at 5:50 P.M.. DSP C indicated when she picked client A up from workshop on 2/23/12, client A was not acting herself, was not able to talk and seemed weak. DSP C stated she walked client A back into the day program to her assigned staff and asked what was wrong with her. The day program staff told DSP client A was not acting herself all day and client A would not eat her lunch which DSP C indicated was not normal for client A. DSP C then walked client A to the Health and Safety Tech to show her how client was acting and to show her a bruise she noticed on client A's head. DSP C indicated the Health and Safety Tech called the group home nurse and informed her of the injury and how client A was acting. DSP C indicated no directives were given by the group home nurse. DSP C then transported client A to the group home and dropped her off to her assigned staff.<br><br>Nursing notation dated 2/23/12: "Received call from group home staff stating that client was not acting herself. Client was able to answer questions when | | | |

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| | asked from staff. Instructed staff to take her v/s (vitals) and call me back...Staff returned call v/s wnl (within normal limits), but client was not answering any questions and staff stated that client eyes were rapidly moving from side to side. I instructed staff to call 911. Client was transported to [Hospital name] for evaluation and treatment."<br><br>An interview with DSP A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated when client A was dropped off at the group home at 4:15 P.M., she was not acting herself. DSP A indicated client A could not talk and was slouched in her wheelchair. DSP A indicated three attempts were made to contact the group home nurse and Service Coordinator, but neither could be reached. DSP A indicated DSP B then called the emergency nursing phone and when the on call nurse called back they informed her client A's condition of not being able to talk and her slouching in her wheelchair. The on call nurse directed the staff to take client A's vitals and call her back. Client A's vitals were taken and they read 163/99 with a pulse of 47 and a temperature of 90.5. The group home staff then called the on call nurse back and as they were giving her client A's vitals, client A's eyes began rolling in the back of her head. DSP A indicated that is | | | |

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| | when the on call nurse gave directives to call 911. DSP A indicated the paramedics arrived around 6:15 P.M..<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12...He stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12."<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated client A's Coumadin was not held on 2/22/12 due to the group home staff not receiving the memo from the nursing staff via e-mail until 2/27/12. DSP A further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12.<br><br>Further review of client A's record indicated: "Health Risk Plan dated 11/3/11-Client has diagnosis of hypertension...Health Risk Plan dated 11/3/11-Client has diagnosis of hyperthyroidism...Health Risk Plan dated 11/3/11-Client has diagnosis of constipation and or bowel obstruction related to hyperthyroidism...Health Risk plan dated 11/3/11-Client is at risk for falls. Gait is unsteady...Health Risk Plan | | | |

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| | dated 11/3/11-At risk for impaired circulation related to fractured clavicle."<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" and health care needs was made on 3/28/12 at 2:30 P.M.. The group home Licensed Practical Nurse (LPN) did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" and health care needs was made on 3/29/12 at 3:00 P.M.. The group home LPN did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home and day services were trained on client A's "Health Risk Plans" was made on 3/30/12. The Service Coordinator and group home LPN indicated there was no documentation to indicate all group home staff were trained on client A's "Health Risk Plans" and health care needs.<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated she never received any training on any of client A's "Health Risk Plans" or medical | | | |

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| | concerns.<br><br>An interview with DSP B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated she never received any training on any of client A's "Health Risk Plans" or medical concerns.<br><br>A review of "Death Investigation-Adequete (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with Service Coordinator A dated 2/24/12: "I got a phone call from [group home name] staff on 2/23/12 stating that they were trying to reach the nurse but could not get a hold of her, that was about consumer bleeding but not badly, location of bleeding was indicated. I [Service Coordinator A name] told that [group home nurse name] was at the office, they said they could not reach her. I said I will have her call you. Then I called [group home nurse name] at the office I told her about the request from group home staff and she needs to call there. I did not hear anything else until 6:30 P.M. on 2/23/12 when I got a call from Area Manager. She said the group home was trying to reach me because consumer was going to the hospital...Consumer was prescribed a | | | |

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| | wheelchair and was moved temporarily to [group home name]."<br><br>Interview with day program DSP D dated 2/24/12: "I worked with [client A] on 2/23/12. I was not on duty when she went to the hospital. Prior to leaving day service [client A] seemed to be very weak when being toileted. Seeming to be spaced out...When [client A] came back to day service from hospital she was in a wheelcahir and seemed to be weak. No special training to render services. I did have health and safety tech look at [client A] she looked different to me. When staff brought her in to me at 9:50 A.M. they told me of a med error. I asked I needed to know anything else and that her arm was bleeding it was cleaned up and nurse knew about it."<br><br>Interview with day program DSP E dated 2/24/12: "I worked with [client A] Wednesdae 2/22/12...I worked at the day program yesterday. I noticed while working with her that her breathing has always been shakey to me and she was thirsty all the time...No I was not trained to render care for [client A]."<br><br>Interview withday program DSP F datetd 2/24/12: "No training for her in particular." | | | |

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| | Interview with day program Health and Safety Tech dated 2/24/12: "I got a call on 2/23/12 by the residential nurse that the staff at the group home had made an error for meds for [client A], and were to be sure to make me aware when they brought her into the center...I knew in the last year and a half that [client A] was falling down alot and she wasn't herself anymore, a little more weak, less talkative not smiling as much, more quiet. Earlier in the afternoon I did check blood pressure, because staff had mentioned that she was breathing funny. Did take and it was 113/77 pulse 61. Called the residential nurse about my concerns and she said that was okay for [client A]. Aagin I called her toward the time staff was picking [client A] upto go home, because her staff had noticed a bruise on the top of her head...I was told her medication could cause her to have unexplained bruising."<br><br>Interview with DSP A dated 2/24/12: "On February 23, 2012, [DSP A] came into work at 4 P.M. at [Group home name] where she came in contact with client A at 4:15 P.M.. [DSP A] was on duty at the time the client went to the hospital. [DSP A] states that the consumer looked pale and was slumped in her wheelchair. [DSP A] didi not call for for help of anyone, another staff called. | | | |

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| | The consumer was not alert or verbal while in [DSP A]'s care. [DSP A] tried to keep consumer lifted by placing her arm under consumer's arm. [DSP A] came off vacation on Monday 2/20/12 and consumer was at the group home, she had not been trained on her...[DSP A] had to call for assistance from a different staff on a separate occasion of [client A] falling on the floor...states she tried to contact [Service Coordinator name] on several occasions to get training on consumer but her calls were not answered...Did not see a risk plan in the house, but she did see the MAR (Medical Administration Record)."<br><br>Interview with DSP B dated 2/24/12: "[DSP B] worked with client A last on 4/23/12 (sic) [DSP B] was on duty when the consumer went to the hospital. [DSP B] states the consumer was not acting her normal self. Consumer words were slured (sic) but consumer barely said anything at all which was not normal. There was no life saving measures taken but [DSP B] did check client A's vital (sic) and found that the consumer's pulse low (it read 42). [DSP B] called the emergency phone to report that the consumer temperature was 90.5. The nurse instructed [DSP B] to call 911. [DSP A and DSP B tried to hold consumer up in her wheelchair but they never took her out of chair. [DSP B] | | | |

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| | states that she was not trained on meeting the care of the consumer...[DSP B] have (sic) not seen a risk plan at the house, but there is a MAR."<br><br>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 2:55 P.M.. The LPN indicated she did not assess client A after each incident she was made aware of. When asked if client A was seen by a physician after the mentioned incidents, the LPN statd "No." When asked if the incident of client A's arm bleeding on 2/23/12 was documented, she stated "No."<br><br>Review of client A's "Indiana State Department of Health Certificate of Death" dated 3/28/12 was conducted on 3/30/12 at 1:30 P.M.. The document indicated client A's cause of death was sudden cardiac arrest and she expired at 8:30 P.M. on 2/23/12.<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-6(a) | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ARC OF NORTHWEST INDIANA INC, THE | 120 AVENUE C<br>GRIFFITH, IN 46319 |

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| W0339 | 483.460(c)(4)<br>NURSING SERVICES<br>Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.<br><br>Based on record review and interview, the facility failed for 1 of 1 discharged client (client A), to develop a plan for her diagnosis of syncope.<br><br>Findings include:<br><br>A review of client A's record was conducted on 3/22/12 at 2:55 PM. Client A's record indicated a nursing notation dated 1/9/12 which indicated: "Received a call from grouphome (sic) staff Saturday stating that [client A] was coming down the steps and sat down and passed out. Came to about 45 seconds later was aware of person, place and time. Diagnosed 3/11 with syncope. Informed staff that this appeared to be a syncope episode and just to continue to monitor and walk with [client A] when possible." Further review of the record failed to indicate a risk plan for client A's diagnosis of syncope.<br><br>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 1:45 P.M.. The LPN stated "There was no syncope risk | W0339 | See W 104 page 3, W 111 page 14 | 04/29/2012 |

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| | plan developed because there is no cure for syncope." When asked what syncope was she stated "Syncope is when oxygen doesn't get to the brain and causes fainting spells." No further documentation was available for review to indicate a risk plan had been developed for client A's diagnosis of syncope.<br><br>9-3-6(a) | | | |

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| W0340 | 483.460(c)(5)(i)<br>NURSING SERVICES<br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.<br><br>Based on record review and interview, the facility nursing services failed to assure staff were trained in health care needs for 1 of 1 discharged client (client A).<br><br>Findings include:<br><br>A review of client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record indicated:<br><br>Nursing notation dated 1/9/12: "Received a call from grouphome (sic) staff Saturday stating that [client A] was coming down the steps and sat down and passed out. Came to about 45 seconds later was aware of person, place and time. Diagnosed 3/11 with syncope. Informed staff that this appeared to be a syncope episode and just to continue to monitor and walk with [client A] when possible."<br><br>Nursing notation dated 2/6/12: "Received a call from staff on Sunday, 2/5/12 stating | W0340 | See W 104 page 3, W 111 page 14 | 04/29/2012 |

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| | that [client A] was very weak and couldn't stand at all. She also lost control of her bowels and bladder at the table and didn't even realize it. I (Nurse) instructed staff to have her transported to the ER (Emergency Room) for evaluations and tx (treatment). Admitted to hospital with UTI (Urinary Tract Infection) and blood clot in left leg."<br><br>Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligrams) qd (everyday)."<br><br>Further review of the record indicated client A was moved to a different group home the day of her discharge from the hospital on 2/11/12 due to her not being able to go up and down stairs.<br><br>Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her lab drawn."<br><br>Nursing notation dated 2/23/12: "Received a call from health tech stating | | | |

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| | that [client A] had an episode at workshop where she was breathing hard for a few seconds. Vitals were taken and were WNL (within normal limits). She stated she seemed normal now and that it only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior."<br><br>Nursing notation dated 2/23/12: "Received a call from North (workshop) stating that there was a small bruise on [client A]'s head that they don't believe was there this morning."<br><br>Nursing notation dated 2/23/12: "Received call from group home staff stating that client was not acting herself. Client was able to answer questions when asked from staff. Instructed staff to take her vitals and call me back...Staff returned call with vitals within normal limits, but client was not answering any questions and staff stated that client eyes were rapidly moving from side to side. I instructed staff to call 911. Client was transported to hospital for evaluation and treatment."<br><br>Nursing notation dated 2/23/12: "Client passed away at hospital."<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the | | | |

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| | Coumadin was not held on 2/22/12...He stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12."<br><br>Further review of client A's record indicated: "Health Risk Plan dated 11/3/11-Client has diagnosis of hypertension...Health Risk Plan dated 11/3/11-Client has diagnosis of hyperthyroidism...Health Risk Plan dated 11/3/11-Client has diagnosis of constipation and or bowel obstruction related to hyperthyroidism...Health Risk plan dated 11/3/11-Client is at risk for falls. Gait is unsteady...Health Risk Plan dated 11/3/11-At risk for impaired circulation related to fractured clavicle."<br><br>A request for documentation to show all staff working at the group home were trained on client A's "Health Risk Plans" was made on 3/28/12 at 2:30 P.M.. The Service Coordinator and group home Licensed Practical Nurse (LPN) did not submit any documentation.<br><br>A request for documentation to show all staff working at the group home were trained on client A's "Health Risk Plans" was made on 3/29/12 at 3:00 P.M.. The Service Coordinator and group home LPN did not submit any documentation. | | | |

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| | A request for documentation to show all staff working at the group home were trained on client A's "Health Risk Plans" was made on 3/30/12. The Service Coordinator and group home LPN there was no documentation to indicate all group home staff were trained on client A's "Health Risk Plans".<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated she never received any training on any of client A's "Health Risk Plans" or medical concerns.<br><br>An interview with DSP B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated she never received any training on any of client A's "Health Risk Plans" or medical concerns.<br><br>A review of "Death Investigation-Adequete (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with DSP A dated 2/24/12: "[DSP A] came off vacation on Monday 2/20/12 and consumer was at the group home, she had not been trained on her... [DSP A] had to call for assistance from a different staff on a separate occasion of | | | |

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| | [client A] falling on the floor...states she tried to contact [Service Coordinator name] on several occasions to get training on consumer but her calls were not answered...Did not see a risk plan in the house, but she did see the MAR (Medical Administration Record)."<br><br>Interview with DSP B dated 2/24/12: "[DSP B] states that she was not trained on meeting the care of the consumer... [DSP B] have (sic) not seen a risk plan at the house, but there is a MAR."<br><br>Interview with day program DSP E dated 2/24/12: "I worked with [client A] Wednesday 2/22/12...I worked at the day program yesterday. I noticed while working with her that her breathing has always been shakey to me and she was thirsty all the time...No I was not trained to render care for [client A]."<br><br>Interview withday program DSP F datetd 2/24/12: "No training for her in particular."<br><br>An interview with the group home LPN was conducted on 3/29/12 at 2:45 P.M.. The LPN stated she did not have any documentation to indicate all group home and day service staff were trained on client A's medical risk plans and medical care needs. | | | |

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| | This federal tag relates to complaint #IN00104522.<br><br>9-3-6(a) | | | |

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| W0368 | 483.460(k)(1)<br>DRUG ADMINISTRATION<br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. | W0368 | See W 104 page 3, W 111 page 14 | 04/29/2012 |

Based on record review and interview, the facility failed to assure 1 of 1 discharged client (client A) received medications in compliance with the physician's orders.

Findings include:

A review of the client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record indicated the following:

Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligram) qd (). Will f/u (follow up) with [Doctor name] on 2/15/12."

Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her

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| | lab drawn."<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12...He stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12."<br><br>An interview with the group home Licensed Practical Nurse (LPN) was conducted at the facility's administrative office on 3/28/12 at 1:45 P.M.. The LPN indicated client A's Coumadin was not held as ordered by the physician. The LPN further indicated client A's Coumadin should have been held as ordered by the physician.<br><br>This federal tag relates to complaint #IN00104522.<br><br>9-3-6(a) | | | |

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| W9999 | | W9999 | See W 104 page 3, W 111 page 14, W 122 | 04/29/2012 |

State Findings:

The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:

460 IAC 9-3-1(b)

The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.

This rule is not met as evidence by:

Based on record review and interview, the facility failed for 1 of 1 investigation record reviewed involving 1 of 1 discharged client (client A), to report Bureau of Developmental Disabilities Services (BDDS) to report an injury of unknown origin and a medication error in a timely manner..

Findings include:

A review of client A's record was conducted on 3/22/12 at 2:55 P.M.. Review of client A's medical record

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| | indicated:<br><br>Nursing notation dated 2/13/12: "Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligrams) qd (everyday)."<br><br>Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her lab drawn."<br><br>An interview with Direct Support Professional (DSP) B was conducted on 3/29/12 at 4:45 P.M.. DSP B indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being aware of the order and not receiving the memo from the nursing staff via e-mail until 2/27/12. No BDDS report was available for review. No documentation was available for review to indicate the administrator was immediately notified of this incident.<br><br>Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12...He | | | |

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| | stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12." No BDDS report was available for review to indicate the facility reported the incident.<br><br>An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M.. DSP A indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being informed to hold it before administering and further indicated the group home did not receive the memo from the nursing staff via e-mail until 2/27/12. No BDDS report was available for review to indicate the facility reported the incident.<br><br>A review of "Death Investigation-Adequete (sic) Care Rendered #16867" was conducted on 3/30/12 at 12:07 P.M.. The record indicated:<br><br>Interview with Service Coordinator A dated 2/24/12: "I got a phone call from [group home name] staff on 2/23/12 stating that they were trying to reach the nurse but could not get a hold of her, that was about consumer bleeding but not badly, location of bleeding was indicated. I [Service Coordinator A name] told that [group home nurse name] was at the | | | |

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| | office, they said they could not reach her. I said I will have her call you. Then I called [group home nurse name] at the office I told her about the request from group home staff and she needs to call there. I did not hear anything else until 6:30 P.M. on 2/23/12 when I got a call from Area Manager. She said the group home was trying to reach me because consumer was going to the hospital...Consumer was prescribed a wheelchair and was moved temporarily to [group home name]." No BDDS report was available for review to indicate the facility reported the incident.<br><br>Interview with day program DSP D dated 2/24/12: "I worked with [client A] on 2/23/12...When staff brought her in to me at 9:50 A.M. they told me of a med error. I asked I needed to know anything else and that her arm was bleeding it was cleaned up and nurse knew about it." No BDDS report was available for review to indicate the facility reported the incident.<br><br>Interview with day program Health and Safety Tech dated 2/24/12: "I got a call on 2/23/12 by the residential nurse that the staff at the group home had made an error for meds for [client A], and were to be sure to make me aware when they brought her into the center." No BDDS report was available for review to indicate | | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARC OF NORTHWEST INDIANA INC, THE | 120 AVENUE C<br>GRIFFITH, IN 46319 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | the facility reported the incident.<br><br>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 2:55 P.M.. The LPN indicated she did not assess client A after each incident she was made aware of. When asked if client A was seen by a physician after the mentioned incidents, the LPN stated "No." When asked if the incident of client A's arm bleeding on 2/23/12 was documented and reported to the administrator and BDDS, she stated "No." When asked if the medication error was immediately reported to the administrator and BDDS, the LPN stated "No."<br><br>An interview was conducted with the Service Coordinator (SC) at the facility's administrative office on 3/28/12 at 2:20 P.M.. The SC indicated incidents are to be reported within 24 hours to BDDS. When asked if the documented incidents was immediately reported, the SC stated "No."<br><br>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 3/26/12 at 7:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting | | | |

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| | and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS...Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:<br><br>2. Alleged, suspected or actual neglect (which must also be reported to Adult Protective Services or Child Protective Services, as indicated) which includes but is not limited to:<br>a. failure to provide appropriate supervision, care, or training;<br>b. failure to provide a safe, clean and sanitary environment;<br>c. failure to provide food and medical services as needed;<br>d. failure to provide medical supplies or safety equipment as identified in the Individual Support Plan (ISP).<br><br>12. Any injury to an individual when the cause is unknown and the injury could be indicative of abuse, neglect or exploitation.<br><br>13. Any injury to an individual when the cause of the injury is unknown and the injury requires medical evaluation or treatment.<br><br>16. A medication error or medical treatment error as follows: | | | |

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| | a. wrong medication given;<br>b. wrong medication dosage given;<br>c. missed medication - not given;<br>d. medication given wrong route; or<br>e. medication<br><br>**Responsible Parties**<br>1. The provider responsible for an individual at the time of the occurrence of a reportable incident shall submit an incident initial report.<br>2. In addition to the provider ' s mandatory reporting, any other person may submit an incident initial report associated with any reportable incident.<br>3. The entity responsible for incident follow-up reports is the individual ' s:<br>a. case manager, when receiving waiver funded services;<br>b. residential provider ' s Qualified Developmental Disabilities Professional (QDDP) when receiving State Line Item (SLI), Supervised Group Living (SGL), or other ICF/MR services<br>c. provider staff when receiving Caregiver Supports Services;<br>d. BDDS service coordinator when receiving other services (e.g. Title XX and nursing facilities).<br><br>**Initial incident reporting to BQIS**<br>1. Within 24 hours of initial discovery of a reportable incident, the reporting person shall file an incident initial report with BQIS using the DDRS approved electronic format available at https://ddrsprovider.fssa.in.gov/IFUR/. In the | | | |

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| | event of a network malfunction, incident initial reports and incident follow-up reports may be e-mailed to BDDSIncidentReports@fssa.in.gov, or faxed to 260-482-3507.<br>2. The reporting person shall be descriptive when completing the narrative portions of the incident initial report form, including:<br>a. a comprehensive description of the incident;<br>b. a description of the circumstances and activities occurring immediately prior to the incident;<br>c. a description of any injuries sustained during the incident;<br>d. a description of both the immediate actions that have been taken, and actions that are planned but not yet implemented; and<br>e. a listing of each person (first name, last initial) involved in the incident, with a description of the role and staff title, if applicable, of each person involved.<br>3. Exhibit " A " of this policy contains additional directives for providing comprehensive and objective information on the incident initial report.<br><br>**Reportable Incident Follow-Up**<br>1. An incident may be closed by BQIS upon receipt and processing.<br>2. If an incident is not closed upon BQIS ' receipt and processing, BQIS shall forward an email notification to the person responsible for incident follow-up reporting.<br>3. The person responsible for incident follow-up reporting shall:<br>a. submit an electronic incident follow-up | | | |

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| | report within 7 days of the date of the incident initial report;<br>b. continue to submit incident follow-up reports on an every 7 day schedule, until such time as the incident is resolved to the satisfaction of all entities;<br>c. forward copies of each follow-up report to the same entities who received a copy of the incident initial report.<br>4. Exhibit " B " of this policy contains additional directives for providing comprehensive and objective information on the incident follow-up report.<br><br>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 3/28/12 at 2:55 P.M.. The LPN indicated she did not assess client A after each incident she was made aware of. When asked if client A was seen by a physician after the mentioned incidents, the LPN stated "No." When asked if the incident of client A's arm bleeding on 2/23/12 was documented and reported to the administrator and BDDS, she stated "No." When asked if the medication error was immediately reported to the administrator and BDDS, the LPN stated "No."<br><br>9-3-1(b) | | | |